Office of the State Employer
Employee Health Management Division

MEDICAL RELEASE – CLAIMANT INFORMATION RELEASE AUTHORIZATION

I, _____hereby authorize and direct any and all medical providers and facilities to release information contained in my patient records, that may relate to my disability claim filed on _____, and to disclose any such information to authorized representatives of the State of Michigan and its third party disability claims administrators, Broadspire, Inc. and Citizens Management, Inc.

This specifically includes, but is not limited to, all medical, psychiatric, dental, hospital, clinical, employment, insurance claims, vocational records, and information. This authorization allows the State of Michigan and its third-party administrators to release the above-mentioned information and records to each other.

This medical release is valid during the pendency of my claim and shall expire when my claim concludes. The purpose of this disclosure is to provide medical and related documentation in order for my claim(s) for disability benefits to be adequately evaluated. This release may be revoked at any time. However, any information already obtained as a result of this release may be used for the purpose of evaluating my disability benefit claim(s). I understand that the records released for the above purpose will be handled in a confidential manner, and utilized only for the purpose of determining my disability benefits.

This medical release can be faxed, or copied, and a fax or photocopy of this medical release is as valid and acceptable as the original medical release. I understand that failure to provide a signed copy of this medical release may prevent the State of Michigan's third-party claims administrators, Broadspire, Inc., and Citizens Management, Inc., from processing my disability claim.

Applicant Signature:_____Date:_____

Witnessed by:_____Date:_____